

EXHIBIT 4

TEST PROTOCOL - FOR USE WITH POINT OF CARE URINE TEST DEVICES
PLEASE COMPLETE, SIGN AND FAX TO CUSTOMER SERVICE AT 858-217-0331

PRACTICE INFORMATION: _____

SALES RE: _____

DATE: _____

A CONFIRMATION OF NEGATIVE POINT-OF-CARE TEST RESULTS

Millennium Laboratories will confirm and quantify all positive Point-Of-Care Test results and will confirm negative results as indicated below.

SELECT WHICH NEGATIVE POINT-OF-CARE RESULTS YOU WOULD LIKE TO HAVE CONFIRMED AND QUANTIFIED BY LC-MS/MS.	ALL
AMPHETAMINES	<input type="checkbox"/>
BARBITURATES*	<input type="checkbox"/>
BENZODIAZEPINES	<input type="checkbox"/>
COCAINE	<input type="checkbox"/>
MDMA	<input type="checkbox"/>
METHAMPHETAMINE	<input type="checkbox"/>
OPIATES	<input type="checkbox"/>
PHENCYCLIDINE	<input type="checkbox"/>
TRICYCLIC ANTIDEPRESSANTS*	<input type="checkbox"/>
cTHC (MARIJUANA METABOLITE)	<input type="checkbox"/>

B TESTING WHICH MAY OR MAY NOT BE ON POINT-OF-CARE TEST

THESE DRUGS MAY OR MAY NOT BE ON YOUR POINT-OF-CARE TEST.
PLEASE INDICATE IF YOU WOULD LIKE TO HAVE THESE QUANTIFIED BY LC-MS/MS.

ALL	<input type="checkbox"/>
BUPRENORPHINE (SUBOXONE®)	<input type="checkbox"/>
METHADONE (METHADOSE®)	<input type="checkbox"/>
OXYCODONE	<input type="checkbox"/>
PROPOXYPHENE (DARVON®)	<input type="checkbox"/>

C ADDITIONAL TESTING NOT INCLUDED ON POINT-OF-CARE TEST

SELECT WHICH DRUGS NOT ON THE POINT-OF-CARE TEST YOU WOULD LIKE TESTED AND/OR QUANTIFIED BY LC-MS/MS.

ORDER SCREEN	ORDER SCREEN AND CONFIRM/ QUANTIFY BY LC-MS/MS	
<input type="checkbox"/>	<input type="checkbox"/>	ALL
<input type="checkbox"/>	N/A	ALCOHOL*
<input type="checkbox"/>	<input type="checkbox"/>	ETHYL GLUCURONIDE
<input type="checkbox"/>	<input type="checkbox"/>	HEROIN
<input type="checkbox"/>	<input type="checkbox"/>	FENTANYL (DURAGESIC®)
<input type="checkbox"/>	<input type="checkbox"/>	CARISOPRODOL (SOMA®)
<input type="checkbox"/>	<input type="checkbox"/>	TRAMADOL (ULTRACET®)
<input type="checkbox"/>	<input type="checkbox"/>	MEPERIDINE (DEMEROL®)
<input type="checkbox"/>	N/A	TAPENTADOL** (NUCYNTA®)
<input type="checkbox"/>	<input type="checkbox"/>	

* Tested by Enzymatic Assay Only ** Tested by LC-MS/MS only

D SPECIMEN VALIDITY TESTING

Millennium Laboratories will perform specimen validity testing (creatinine, pH, specific gravity and oxidants) *unless* otherwise indicated here.

☐ DO NOT perform Specimen Validity Testing

E SPECIAL INSTRUCTIONS

AUTHORIZATION

I authorize Millennium Laboratories to perform drug testing on all specimens submitted from my practice as follows:

1. Confirm and quantify all positive Point-Of-Care Test results indicated on the individual patient requisition form.
2. Confirm and quantify negative Point-Of-Care Test results as indicated above in Section A, and on the individual patient requisition form.
3. Confirm and quantify all positive Additional Test results pursuant to Section C above.
4. Perform any additional testing (including confirmation of negatives) requested in Sections B and C, and on the individual patient requisition form.
5. Perform specimen validity testing (unless otherwise indicated in Section D).
6. Perform any 'Special Instructions' as specified in Section E.

I acknowledge that the test panels defined on this Test Protocol are not AMA-approved panels, but nonetheless may be deemed medically necessary because of the clinician's legal and regulatory obligation to take reasonable steps to prevent abuse and diversion of controlled medications. I understand that I may order any of the above-stated tests separately or in necessary combination consistent with the patient's individual medical needs.

I understand this Test Protocol may be modified in writing at any time; otherwise, this Test Protocol will remain in effect for one year from date of signing.

Signatures for all physicians sending samples to Millennium Laboratories are required.

Physician's Name: _____

Physician's NPI#: _____

Signature: _____ Date: ____/____/____

Physician's Name: _____

Physician's NPI#: _____

Signature: _____ Date: ____/____/____

Physician's Name: _____

Physician's NPI#: _____

Signature: _____ Date: ____/____/____